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STUDY PROJECT

THE ARMY DENTAL CARE SYSTEM: 1975 - 1989

BY

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5 FEBRUARY 1990

U.S. ARMY WAR COLLEGE, CARLISLE BARRACKS, PA 17013-5050

SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER	2. GOVT ACCESSION NO.	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) The Army Dental Care System: 1975-1989		5. TYPE OF REPORT & PERIOD COVERED
		6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Thomas G. Reddy, Jr., COL, DE		8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS U.S. Army War College Carlisle Barracks, PA 17013-5050		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS
11. CONTROLLING OFFICE NAME AND ADDRESS Same		12. REPORT DATE 5 February 1990
		13. NUMBER OF PAGES 23
14. MONITORING AGENCY NAME & ADDRESS(if different from Controlling Office)		15. SECURITY CLASS. (of this report) Unclassified
		15a. DECLASSIFICATION/DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT (of this Report)

Approved for public release; distribution is unlimited.

17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)

18. SUPPLEMENTARY NOTES

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

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SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

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USAWC MILITARY STUDIES PROGRAM PAPER

THE ARMY DENTAL CARE SYSTEM: 1975 - 1989

An Individual Study Project
Intended for Publication

by

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5 February 1990

ABSTRACT

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TITLE: The Army Dental Care System: 1975 - 1989

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DATE: 5 February 1990 PAGES:20 CLASSIFICATION:Unclassified

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> On a slightly different tack, I must say that your officers, dentists, and all the support staff, ...demonstrate more initiative than do their counterparts in MEDDAC. I don't know why this is, but I only know this is the case.
>
> MG, Division Commander

> First and foremeost, I am impressed with the members of our Dental Corps as soldiers as well as dentists. They provide sterling examples of what professionals can do and be when properly motivated.
>
> MG, Installation Cdr

INTRODUCTION

This study will examine the changes that occurred, beginning in 1975, within both the Army Medical Department (AMEDD) and the U.S. Army Dental Corps and attempt to justify perceptions such as those expressed by the above two senior Army leaders.<1> While legislation authorizing the U.S. Army Dental Corps was signed on 3 March 1911, the Army Dental Care System, as it exists today, had its beginnings on 20 October 1978 with another piece of legislation.<2> The 1979 Defense Authorization Bill directed that dental matters be referred to the Chief of the Dental Corps, and that dental units be commanded by a Dental Corps officer who will be directly responsible to the installation commander.

Prior to this all health care resources on the installation were under a single command, and that commander was a physician. Since such an arrangement at first glance appears to be both logical and cost effective, two questions come to mind: Why change it; and, having done so, is it any better? This study will be limited to providing answers to those questions and thereby provide some insight into senior leader perceptions.

BACKGROUND

After a long history of leadership and representation by Medical Corps officers (physicians) of the Army Medical Department (AMEDD), the U.S. Army Dental Corps finally achieved a minor degree of autonomy with the passage of the National Defense Act of 1947.<3> Although this legislation allowed dental units to be commanded by dental officers under the direct command of the installation commander, it still left the Surgeon General of the Army, a physician, to represent the dental profession to the Department of the Army, the Department of Defense, and the Congress. In 1967, AR 40-4 established the Medical Support Activity (MEDSAC), which evolved into the Medical Department Activity (MEDDAC) one year later.<4> This concept placed all health care assets on an installation under a single commander. Only that commander, a physician, would be directly responsible

to the installation commander. In effect, the dental community had lost its voice at the installation level, and another layer of administration had been imposed between the installation dental activity and assistance or supervision by a dental staff officer.

So, you ask, what's the problem? We're all health care providers within the Army Medical Department family. The resulting administrative structure will be leaner and more cost effective. The Surgeon General will certainly be a fair broker and voice dental concerns to the Army Staff. The MEDDAC commander would be much too busy to be involved in dental issues, and would leave these and the day to day operation of dental clinics to dental officers. Apparently the Army Dental Corps must have shared these views, since it presented virtually no opposition to the implementation of the MEDDAC concept in 1968.

It was during this same period that methods to account for dental workload were changed so that only the number of patient visits were recorded rather than accounting for actual dental procedures as had been previously done.<5> In 1974, Congress directed a change back to the prior method of accounting for actual dental procedures rather than counting the number of patient visits. Dental procedures, whether they involved cleaning teeth or removal of impacted third molars, could be readily compared since a weighted value was assigned to each procedure, based upon the time required to perform that procedure. Congress directed the change in

order to be able to compare the productivity levels of the Army, Navy and Air Force Dental Corps. Inadvertently, the directed change in accounting methods had made it a fairly simple task to compare the dental care productivity of Army dental officers, before and after implementation of the MEDDAC concept. At the time, the change was perceived to be nothing more than a nuisance, although it would ultimately prove to be a significant factor in the eventual creation of the Army Dental Care System.

It was found that the average daily number of dental procedures performed by a dental officer had fallen from 18.9 in the first quarter of fiscal year 1964 to 15.7 in the second quarter of fiscal year 1975 -- a 17% decrease.<6> At the same time, it was revealed that, in 1974, the Army Dental Corps had the lowest retention rate of young officers in the entire Army; 7.1% (Fig.1). Even more remarkable was the fact that the Army Medical Department was retaining almost 30% more eligible junior physicians than dentists. The retention numbers were expected to be low; after all, most of the eligible officers had been subject to the draft during an unpopular war that had recently ended. Still, the rest of the Army was retaining junior officers at a rate six times greater than the Dental Corps. When given these numbers, the Army Surgeon General formed an Ad Hoc Committee of General Officers on 11 February 1975, and directed them to review the organization for dental services in the Army and make recommendations for change.

RETENTION OF JUNIOR OFFICERS BY BRANCH

(OTRA - OTHER THAN REGULAR ARMY)

1974

BRANCH	% RETAINED
Armor	30.6
Air Defense Artillery	33.9
Field Artillery	31.6
Infantry	34.5
Chemical	40.8
Engineer	64.8
Ordnance	51.6
Quartermaster	54.3
Signal	49.2
Transportation	42.8
Adjutant General	45.7
Finance	50.6
Military Police	42.3
Military Intelligence	51.3
Total	43.8
Chaplain	67.1
Judge Advocate General	10.6
Medical	9.2
Dental	7.1
Veterinary	21.7
Medical Service	19.5
Nurse	17.3

Source: MILPERCEN COPO-67

FIGURE 1.

The committee identified several basic areas of concern in their report to the Surgeon General.<7> There was an apparent lack of professional review and accountability of dental activities. Administrative support for dental activities was limited, as was control over dental resources by dental officers. Finally, several instances of problems in command relationships were discovered between physicians and dentists within the MEDDACs.

Specific examples of problems on which these concerns rested were identified. Among them were that approximately 0.05% of Medical Service Corps officers were assigned to dental organizations. Also, a Medical Center (MEDCEN) diverted almost $100,000 in fenced funds and 12 authorized civilian dental assistant spaces away from the dental activity for its own use. A MEDDAC commander appropriated a building designated and renovated by the post for the dental activity three years earlier. Medical Corps officers were averaging almost four times as many TDY trips as Dental Corps officers -- a significant disparity, because these TDY trips constituted the vast majority of continuing education opportunities that were available. As of July 1975, 63% of dental clinics were housed in temporary structures and less than three percent of the total medical construction program (MCA) over the previous five years was devoted to dental facilities.

Clearly, there were significant problems within both the Army Medical Department and the U.S. Army Dental Corps.

The Surgeon General's review began the process that would eventually lead to the creation of the Army Dental Care System.

1975 - 1978: REGULATORY & LEGISLATIVE CHANGES

As a result of the concerns raised by The Surgeon General's review, Headquarters, Department of the Army sent a message to the field on 26 August 1975 under the subject "Installation Dental Service Management".<8> Effective 1 September 1975, in order "to give more visibility and command emphasis to installation level dental programs", all CONUS (Continental United States) installations would have a Director of Dental Services (DDS) appointed by the Commanding General, U.S. Army Health Services Command, with the concurrence of the installation commander. Furthermore, the installation commander was "encouraged to communicate directly with the DDS" and would be either the rating or indorsing officer on the DDS' Officer Efficiency Report (OER). With this action, dental services had regained an equal footing with other health services on CONUS installations. Equally important, dentists would now have greater responsibility in managing dental activities -- although they would still remain under the command of a Medical Corps officer, who would be a physician.

Major General Surindar N. Bhaskar was appointed as the Assistant Surgeon General and Chief, U.S. Army Dental Corps,

on 1 September 1975. He was determined to demonstrate to the Army that the Installation Dental Service Management Program would be an overwhelming success. With demonstrated success, world-wide implementation along with significantly greater responsibilities would likely follow. Existing policies and procedures were reviewed with particular attention given to those that interfered with patient care, and that impacted on morale and, ultimately, retention. Some significant changes took place in the way the Dental Corps did business following this review. To begin with, the Dental Corps became the first AMEDD corps to hold a command selection board for DENTAC command and other key positions. Selection was based upon demonstrated military and professional excellence, and not upon seniority. Additionally, the time available for patient care was increased greatly by eliminating four-and-one-half-day workweeks, part-time dental school teaching, and excessive continuing education during duty hours. Finally, all dental officers were required to practice dentistry to some degree every week -- even clinic chiefs and commanders.<9>

By the end of the first year of the program, an increase of 30% in the average daily dental procedures provided per dentist was achieved.<10> In December 1977, the Vice Chief of Staff of the U.S. Army directed that the Installation Dental Management Program be implemented world-wide by directing changes to Army Regulations, AR 40-1<11> and AR 40-4<12>. These regulatory changes significantly altered

the subordinate position that dental services had previously occupied within the Army Medical Department. The regulations directed the establishment of Dental Activities (DENTACs) as subordinate major elements of major Army Medical Department commands. DENTACs would now be supported by, rather than subordinate to MEDCEN/MEDDAC commanders. Additionally, the DENTAC, and for the first time, all assigned enlisted personnel, would be commanded by a dental officer. Perhaps most importantly, the Chief of the Army Dental Corps would now assume responsibility for the dollars and the personnel required to support the Army Dental Care System. He also now had access to the Army Staff.

Two other significant concessions were obtained by Major General Bhaskar during this time. First, priority was given to a program to hasten the replacement of temporary wooden dental clinics with modern facilities designed to enhance conditions for both staff and patients. Second, the Army Medical Department agreed to significantly increase the number of Medical Service Corps (MSC) officers assigned to dental organizations. As DENTAC XO's, these officers not only enabled DENTAC commanders to again practice dentistry; more importantly, they brought a wealth of management, personnel and budgetary skills to the dental activities that were in very short supply prior to their arrival.

At this point, the Army Dental Care System seemed to be solidly in the hands of dental officers and well supported

by Army Regulations. What more was left to be done, other than to demonstrate the wisdom of being awarded increased responsibility to manage dental care within the Army? In a letter to the Secretary, Council on Federal Dental Services, American Dental Association, Major General Bhaskar remarked that "...these changes were administrative in nature. That is, they were changes in policy implemented with a 'stroke of the pen' and just as easily changed tomorrow...."<13> The purpose of the letter was to obtain the support of the American Dental Association regarding proposed legislation that would incorporate these administrative changes into law, thereby increasing the difficulty of "changing them tomorrow".

Support for the proposed legislation was decidedly mixed within both the Army Medical Department and the Army Staff. Secretary of the Army, Howard H. Callaway, wrote to Rep. Melvin Price, Chairman, Committee on Armed Services, that<14> "The Department of the Army on behalf of the Department of Defense is opposed to enactment of H.R.3042 ..." and then listed eleven points justifying his position. A difficult battle ensued; and, on 20 October 1978, President Jimmy Carter signed the 1979 Defense Appropriation Authorization Act into law. Contained within this act was a bill commonly known as the Price Bill or Dental Corps Reform Bill. In effect this bill modified Title 10, United States Code, section 3081 as follows:<15>

"#3081. Dental Corps.

"(a) The Chief of the Dental Corps shall be an officer of that corps appointed as prescribed in section 3040 of this title.

"(b) Under such regulations as the Secretary of the Army may prescribe, all dental functions of the Army shall be under the direction of the Chief of the Dental Corps. All matters relating to dentistry shall be referred to the Chief of the Dental Corps.

"(c) The Chief of the Dental Corps shall --

"(1) establish professional standards and policies for dental practice;

"(2) initiate and recommend action pertaining to organization requirements and utilization of the Dental Corps and dental auxillary strength, appointments, advancement, training assignments, and transfer of dental personnel; and

"(3) serve as the advisor to the Office of the Surgeon General on all matters relating directly to dentistry.

"(d) Under such regulations as the Secretary of the Army may prescribe, dental and dental auxillary personnel throughout the Army shall be organized into units commanded by a designated Dental Corps Officer. Such officer will be directly responsible to the commander of installations, organizations, and activities for all professional and

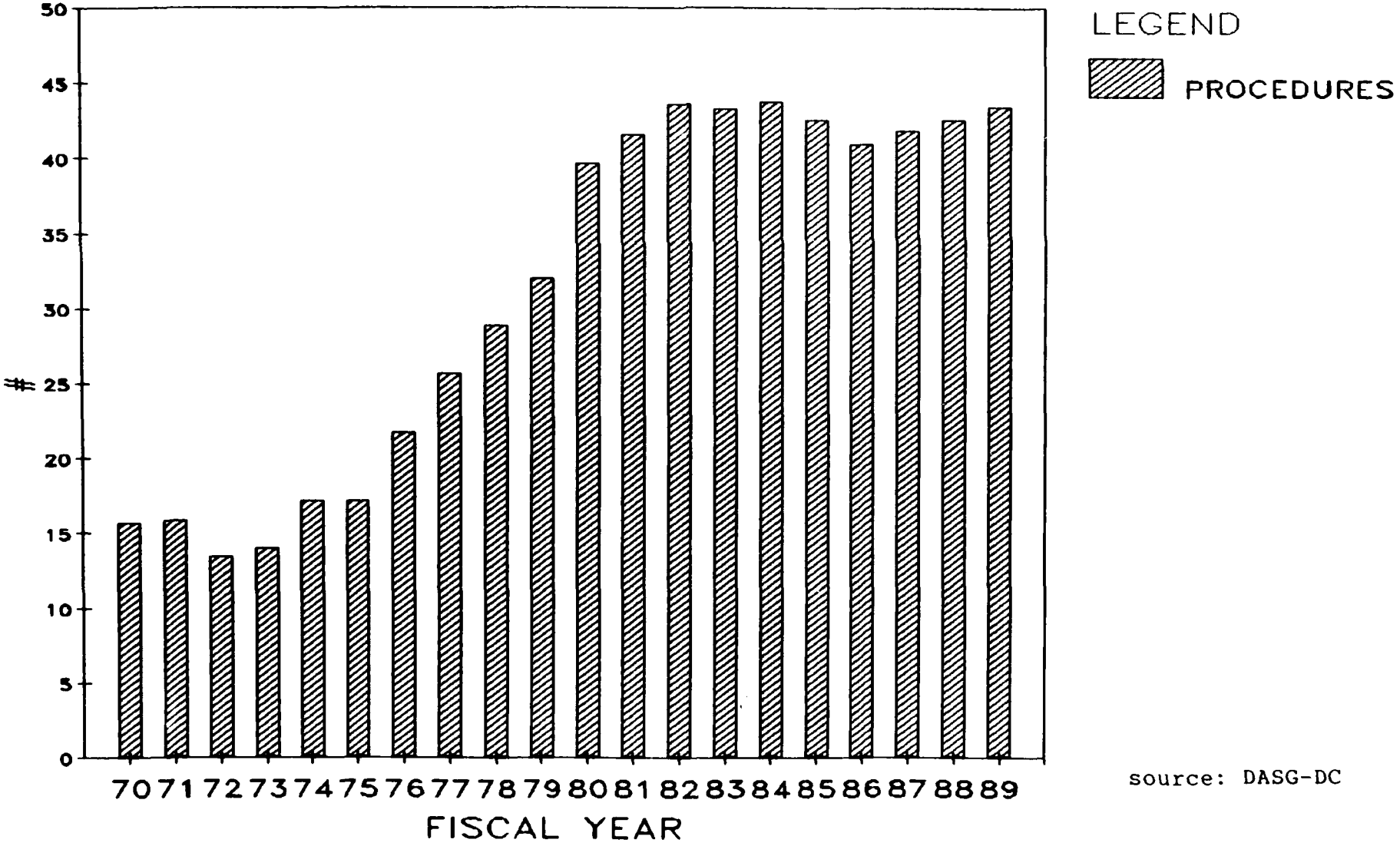
technical matters and such administrative matters as may be prescribed by regulation."

The U.S. Army Dental Corps had accomplished more than was thought possible three years earlier. In addition to legislative control of Army dentistry, a major new program to construct modern dental clinics was under way and the Army Dental Care System was strengthened significantly with addition of the administrative expertise of the Medical Service Corps officers assigned to dental organizations. The responsibility for the success, or failure, of the Army Dental Care System now rested solely in the hands of the U.S. Army Dental Corps.

1978 - 1989: RESULTS & PERCEPTIONS

Two areas easily lend themselves to measurement and to a lesser degree analysis. First, one of the indicators of dental care productivity is the measurement of average daily dental procedures provided per day by dental officers. In addition to productivity, the poor retention rate of dental officers was one of the factors that precipitated the study by the Surgeon General which ultimately led to the 1978 legislation. Comparison of productivity and retention from 1975 through 1989 is fairly simple (Fig.2 & 3). A 153% increase in productivity from 1975 to 1989 was matched by over a six-fold increase in retention of junior eligible

AVERAGE DAILY DENTAL PROCEDURES PER DENTIST 1970 - 1989



source: DASG-DC

FIGURE 2.

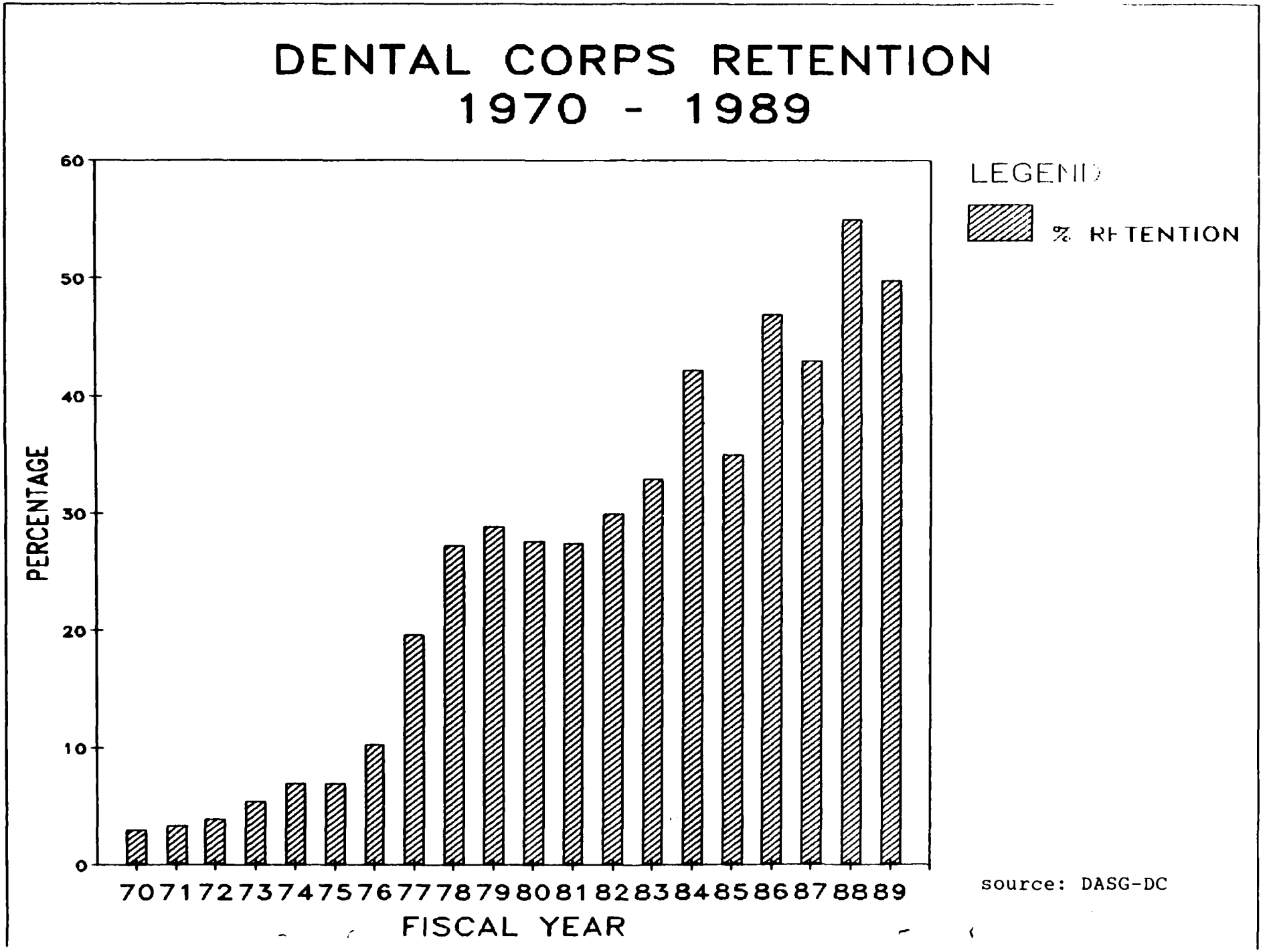

DENTAL CORPS RETENTION
1970 - 1989
PERCENTAGE
60
50
40
30
20
10
0
LEGEND
% RETENTION
70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89
FISCAL YEAR
source: DASG-DC

FIGURE 3.

dental officers during the same period. Even allowing for a change in accounting methodology during this period, these numbers are certainly remarkable and would seem to indicate that the Army Dental Care System post-1978 has been a huge success. Any analysis of the reasons behind these numbers would, of course, be highly subjective. Nevertheless, some suggestions will be offered in an attempt at explanation.

The project begun in fiscal year 1975 to replace temporary wooden dental clinics with modern and efficient facilities is virtually complete with the remaining 18 clinics either under design or in construction.<16> To date, 41 dental clinics, 15 combined health and dental clinics, as well as four extensive clinic renovations have been completed. It is impossible to accurately assess what the effect of more pleasant and efficient surroundings has had upon productivity or, for that matter, retention. In all probability, replacing over 2500 dental operatories in the past 14 years has had a positive impact, although how significant is open to speculation.

Again, it is difficult to quantify the impact of either command selection boards for dental commanders or the gain in administrative support provided by the increased number of Medical Service Corps officers. Selection of dental commanders based upon demonstrated excellence rather than date of rank, along with the administrative expertise provided by medical service staff officers would be expected

to enhance the leadership and management and skills found at headquarters and staff organizations within the Army Dental Care System. Enlightened leadership of officer, enlisted and civilian personnel along with more effective management of resources has likely had a positive impact upon dental productivity, efficiency, morale and retention. How much is difficult to assess.

Although recent years have seen evidence of recruitment problems related to dental school closures, shrinking dental school enrollments and a general lack of recruiting incentives, retention of eligible junior officers remains high. With little doubt, the factor most responsible is the opportunity for post-graduate education available within the Dental Corps today.<17> The Army Dental Care System has developed an extensive educational system. It currently operates 25 residency training programs in eight dental specialities with six additional specialty residency training programs available at other federal agencies or civilian institutions.<18> Competition for the approximately 60 slots available each academic year is keen as evidenced by the 250 to 300 applications received annually. The intense competition for training slots is in part due to the fact that career progression in the U.S. Army Dental Corps is closely related to demonstrated excellence in a dental specialty.

In August of 1988, the current Chief of the Army Dental Corps, Major General Bill B. Lefler, corresponded with 85 General Officers in the United States Army and sought their feedback on their experiences with the Army Dental Care System. The perceptions of senior leaders at the very highest levels of the U.S. Army indicate that the Army Dental Care System is a success.<19> "Since the inception of DENTACs, in 1978, I have witnessed a dramatic increase in the amount of dental care provided to our soldiers, family members and retirees. You have proven that the DENTAC system is successful." "I value highly the direct access afforded me to the DENTAC commander. There is a marked increase in the professionalism and military qualifications of Dental Corps officers. I see higher morale within those ranks." The Sergeant Major of the Army commented that "Dental care ranks number one, by far, among all the services on post. I'd give it a nine on a scale of one to ten."<20>

The office of the Chief of the Army Dental Corps has tracked a number for the past several years that gets right to the "bottom-line". Dental Return on Investment is a figure obtained by balancing the total cost of the Army Dental Care System (salaries, facilities, supplies, etc.) against the estimated dollar value of dental care provided by that system in a fiscal year. The most recent figures available for a complete fiscal year show that the U.S. Army

realized a 21 percent return on investment in fiscal year 1988. Total expenses of $257 million were exceeded by dental services estimated (American Dental Association suggested fees) at $311 million.<21> The Army Dental Care System turned a profit of $54 million in fiscal year 1988.

CONCLUSION

The US Army Dental Corps, with the legislation that created the Army Dental Care System on 20 October 1978, had finally achieved the separation they long desired from their physician colleagues. The ensuing eleven years of relative autonomy seems to have left a record of achievement easily justifying the changes which occurred between 1975 and 1978. The numbers reflect a dramatic increase in dental workload productivity as well as junior dental officer retention. Enlightened leadership, progressive resource management, and state-of-the-art facilities appear to have revitalized the Dental Corps beyond all reasonable expectations.

ENDNOTES

1. Bill B. Lefler, U.S. Department of the Army, letter to 85 General Officers, 31 August 1988. (60 responses on file at OTSG-DSAG-DC, Washington)

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16. Personal communication with COL Patrick D. Sculley, The Dental Consultant, OTSG-DASG-DC, Washington, 21 December 1989.

17. Interview with Major General Bill B. Lefler, 20 December 1989.

18. Gary W. Allen, "US Army Dental Corps Graduate Dental Education Programs and Centrally Funded Short Courses," Medical Bulletin, September/October 1988, pp. 8-10.

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